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| **PERSONAL INFORMATION -** *PLEASE PRINT CLEARLY* |

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| TODAY'S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pronoun(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_   LEGAL/INSURANCE NAME (*if different*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: M\_\_\_\_\_\_D\_\_\_\_\_\_\_Y\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_ EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *STREET CITY STATE ZIP* |
| BEST PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hm off cell  Can we leave messages at this number? YN  |
| ALT PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hm off cell  Can we leave messages at this number? YN  |
| OCCUPATION (previous if retired) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| EMERGENCY CONTACT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *NAME PHONE RELATION* |
|   |
| HOW DID YOU HEAR ABOUT US?  Patient/Friend/Family  Healthcare practitioner  Internet   Other Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 740 N. Lake Avenue • Pasadena, CA 91104*tel:* (626) 794-4668 • *fax:* (626) 345-9753*email*: info@pasadenanaturealhealth.com*web*: pasadenanaturalhealth.com | Paracelsus logo.jpg | 112 E. Olive Avenue, Suite E • Redlands, CA 92373*tel:* (909) 793-4477 • *fax:* (909) 793-9350*email:* info@redlandsnaturalhealth.com*web:* redlandsnaturalhealth.com |
| **Daniel Brousseau, D.O. • Simon Barker, N.D. • Nadia Mistry, N.D.**  |
| **ADULT INTAKE** |

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| PLEASE LIST YOUR HEALTH CONCERNS: |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **PERSONAL MEDICAL HISTORY -** *Check all that apply, please note when they started* |

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| \_\_\_\_\_ AIDS/HIV Infection\_\_\_\_\_ Allergies\_\_\_\_\_ Anemia\_\_\_\_\_ Arthritis\_\_\_\_\_ Asthma\_\_\_\_\_ Attempted Suicide\_\_\_\_\_ Cancer\_\_\_\_\_ Chickenpox\_\_\_\_\_ Chronic Fatigue Syndrome\_\_\_\_\_ Depression\_\_\_\_\_ Eating Disorder\_\_\_\_\_ Eczema\_\_\_\_\_ Edema (Fluid Retention) | \_\_\_\_\_ Fibromyalgia\_\_\_\_\_ Frequent Steroid Use\_\_\_\_\_ Gallbladder Disease\_\_\_\_\_ Glaucoma\_\_\_\_\_ Gout\_\_\_\_\_ Hayfever\_\_\_\_\_ Heart Disease\_\_\_\_\_ Hepatitis B or C\_\_\_\_\_ High Blood Pressure\_\_\_\_\_ Hives\_\_\_\_\_ Kidney Infections\_\_\_\_\_ Kidney Stones\_\_\_\_\_ Liver Disease | \_\_\_\_\_ Lyme Disease\_\_\_\_\_ Migrane Headaches\_\_\_\_\_ Mononucleosis\_\_\_\_\_ Neurological Disorder\_\_\_\_\_ Occupational Exposure to Toxic Substances\_\_\_\_\_ Polio\_\_\_\_\_ Seizure Disorder\_\_\_\_\_ Sleep Apnea\_\_\_\_\_ Stroke/TIA\_\_\_\_\_ Substance Abuse/Addiction\_\_\_\_\_ Thyroid Disease\_\_\_\_\_ Tuberculosis or Positive TB Test |

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| **PERSONAL MEDICAL HISTORY** *(cont'd)* |

Do you have a specific spiritual practice? Y N

 *If so, please describe it:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Is there anything the doctor should know in relation to this?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list the names of your healthcare providers:**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all prescription and over the counter medications that you are currently taking:**

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| --- | --- | --- | --- |
| ***Medication*** | ***Dose*** | ***Date Started*** | ***Prescribed By*** |
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**Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking:**

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| ***Supplement*** | ***Dose*** | ***Date Started*** |
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Please list any severe or life-threatening allergies:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please Explain*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Habits**

Please indicate which substances, if any, pertain to you **N** = use **NOW** **P** = used in the **PAST**

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| ***Substance*** | ***N / P*** | ***How Much?*** | ***How Long?*** | ***Substance*** | ***N / P*** | ***How Much?*** | ***How Long?*** |
| Tobacco |  |  |  | Soda |  |  |  |
| Coffee |  |  |  | Alcohol |  |  |  |
| Black Tea |  |  |  | Recreational Drugs |  |  |  |

Do you have any dietary restrictions or follow a particular dietary regimen? If yes, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? Yes No What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PERSONAL MEDICAL HISTORY** *(cont'd)***Review of Systems** |  *Please indicate the following:* **N** = a condition you have **NOW** **P** = a condition you have had in the **PAST** |
| HeadMigraines\_\_\_\_\_ Headaches\_\_\_\_\_ Location of pain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Worse: Light \_\_ Noise\_\_ Odors\_\_Head Injury \_\_\_\_\_\_\_Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TMJ \_\_\_\_\_\_\_Dizziness \_\_\_\_\_\_\_Fainting \_\_\_\_\_\_\_Seizures \_\_\_\_\_\_\_DigestionBowel Movement \_\_\_\_\_\_\_X per day: 1-2\_\_\_ 2-3\_\_\_ 3-4\_\_\_ orX per week: 1-2\_\_\_ 2-3\_\_\_ 3-4\_\_\_Size: Sm Med LgColor: Brown Tan RustTexture: DryHardWet/Loose PelletsStools with Mucous BloodHemorrhoids \_\_\_\_\_\_\_ Bleeding PainfulItchingFissures/Fistulas \_\_\_\_\_\_\_Stool Incontinence \_\_\_\_\_\_\_Bowel Disease \_\_\_\_\_\_\_Liver/Gallbladder Disease \_\_\_\_\_\_\_Ulcer \_\_\_\_\_\_\_Heartburn \_\_\_\_\_\_\_Bloating \_\_\_\_\_\_\_Belching \_\_\_\_\_\_\_Gas / Flatus \_\_\_\_\_\_\_Nausea / Vomiting \_\_\_\_\_\_\_Pains / Cramps \_\_\_\_\_\_\_**Sleep**Good BadHow many hours? \_\_\_\_W Wake Easily? Yes NoWhy?\_\_\_\_\_\_\_\_\_When?\_\_\_\_\_\_\_\_\_Di Difficulty Falling Asleep? Yes NoW Wake Refreshed? Yes NoGrumpy? Yes NoSnore? Yes No Talk? Yes NoGrind Teeth? Yes NoSleepwalk? Yes NoNightmares? Yes NoDream a lot? Yes NoPreferred Sleeping Position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Sex/Reproductive** |  |
| Change in Sex DriveSexually Transmitted Diseases | \_\_\_\_\_\_\_\_\_\_ |
| Painful Intercourse | \_\_\_\_\_ |
| Ever Have an Abnormal Pap Smear? | \_\_\_\_\_ |
| History of Sexual AbuseDES Exposure | \_\_\_\_\_\_\_\_\_\_ |
| Frequent Yeast Infections | \_\_\_\_\_ |
| Vaginal Discharge | \_\_\_\_\_ |
| Age Period Began | \_\_\_\_\_ |
| Regular Periods Yes  No  | \_\_\_\_\_ |
| Flow: Heavy  Medium  Light  | \_\_\_\_\_ |
| Length of Cycle \_\_\_\_ Days of Flow \_\_\_\_ |  |
| Spotting | \_\_\_\_\_ |
| Cramps | \_\_\_\_\_ |
| PMS\_\_\_\_ Endometriosis\_\_\_ PID\_\_\_ |  |
| Fibroids\_\_\_\_\_\_ Ovarian Cysts\_\_\_\_\_\_ |  |
| Ever Used Birth Control Pills? | \_\_\_\_\_ |
|  How Long For?\_\_\_\_\_ How Long Ago?\_\_\_\_\_ |
| Present Birth Control | \_\_\_\_\_ |
| Pregnancies (number) | \_\_\_\_\_ |
| Childbirth (number) | \_\_\_\_\_ |
| Complications | \_\_\_\_\_ |
| Miscarriages (number) | \_\_\_\_\_ |
| Abortions (number) | \_\_\_\_\_ |
| Have You Had A Hysterectomy? | \_\_\_\_\_ |
| Age at Menopause | \_\_\_\_\_ |
| Vaginal Dryness | \_\_\_\_\_ |
| Hot Flashes | \_\_\_\_\_ |
| Mammograms (number) | \_\_\_\_\_ |
| Date of Last Mammogram | \_\_\_\_\_ |
| Prostate Enlargement | \_\_\_\_\_ |
| Change in Force of Urine Stream | \_\_\_\_\_ |
| Difficulty Starting Urine | \_\_\_\_\_ |
| History of Undescended Testes | \_\_\_\_\_ |
| Pain / Lump in Scrotum | \_\_\_\_\_ |
| Discharge From Penis | \_\_\_\_\_ |
| Difficulty with Erections | \_\_\_\_\_ |
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| **PAST MEDICAL HISTORY** |  *Please provide the following information* |

Hospitalization(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Serious Illnesses and Injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Date of Last Physical\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Blood Tests\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Last Colonoscopy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last DEXA (bone density test)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **FAMILY MEDICAL HISTORY** |  *Please indicate the following:* **YES** = Checkmark applies to you or one of your family members **RELATION** = Self, or indicate family member (mother, aunt, father, etc. **PAST** (**P**) = A condition you've had in the past **Now** (**N**) = A condition you have now |
| **CONDITION** | **YES** | **RELATION** | **NOW (N)/****PAST (P)** |
| Alcoholism/Drug Addiction |  |  |  |
| Alzheimer’s Disease |  |  |  |
| Anemia |  |  |  |
| Cancer |  |  |  |
|  - Type: |  |  |  |
|  - Type: |  |  |  |
|  - Type: |  |  |  |
| Diabetes |  |  |  |
| Heart Disease |  |  |  |
| Osteoporosis |  |  |  |
| Thyroid Disease |  |  |  |
| Other: |  |  |  |
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**•END•**

**Thank you.**

 **Please return your completed forms to our front desk.**

**Your new Doctor will be with you shortly!**